

# Multiresolution wavelet analysis of heartbeat intervals discriminates healthy patients from those with cardiac pathology

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We applied multiresolution wavelet analysis to the sequence of times between human heartbeats (R-R intervals) and have found a scale window, between 16 and 32 heartbeats, over which the widths of the R-R wavelet coefficients fall into disjoint sets for normal and heart-failure patients. This has enabled us to correctly classify every patient in a standard data set as either belonging to the heart-failure or normal group with 100% accuracy, thereby providing a *clinically* significant measure of the presence of heart-failure from the R-R intervals alone. Comparison is made with previous approaches, which have provided only *statistically* significant measures.

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Multiresolution wavelet analysis [1–5] has proved to be a useful technique for analyzing signals at multiple scales, even in the presence of nonstationarities which often obscure such signals [6,7]. The sequence of times between human heartbeats (R-R intervals) is a prototype of a nonstationary time series that carries information about the state of cardiovascular health of the patient [8,9].

By projecting this sequence into a wavelet space, a new set of variables is obtained, whose statistics allow us, for the first time, to correctly classify every patient in a standard data set as either heart-failure or normal, with 100% accuracy. It is clear from our results that the R-R intervals alone suffice as a measure for the presence of heart-failure; the full electrocardiogram is not required. This remarkable result arises from the ability of multiresolution analysis to simultaneously and compactly monitor multiple time scales and thereby to expose a hitherto unknown scale window (between 16 and 32 heartbeats) over which the widths of the R-R wavelet coefficients fall into disjoint sets for normal and heart-failure patients. The emergence of this particular scale window should help shed light on the underlying dynamics of cardiovascular function [9]. Previous approaches [10–12], even those that have made use of wavelets [13], have been successful only in providing a *statistically* significant measure, rather than the *clinically* significant one we have developed. The analysis method we have used is applicable to a wide variety of nonstationary physical and biological signals, regardless of whether the underlying fluctuations have stochastic origins or arise from nonlinear dynamical processes.

The series of intervals between adjacent heartbeats  $\tau_i$  (known as R-R or interbeat intervals in cardiology; see Fig. 1a and 1b) is thought to result from a complex superposition of multiple physiological processes at their respective characteristic time scales [9]. The object of this letter is to demonstrate that it is possible, without any *a priori* knowledge of the physiological time scales or underlying heart dynamics, to determine a range of scales over which a statistic of the wavelet coefficients permits each heart-failure and normal patient to be correctly categorized.

Scale-dependent statistics are constructed by transforming the discrete-time sequence of R-R intervals  $s = \{\tau_i\}$  [14] into a space of wavelet coefficients. One can think of the transformed signal in terms of a landscape over a two-dimensional plane whose axes are interbeat-interval number  $i$  and scale  $m$  (see Fig 1c). Smaller scales correspond to more rapid variations and therefore to higher frequencies. The height is the value of the corresponding wavelet coefficient. With such a three-dimensional construct it is possible to trace the relative importance of different scales as the heartbeat sequence proceeds. Technically the coefficients are obtained by carrying out a discrete wavelet transform (DWT) [1,4]

$$W_{m,n}^{\text{wav}}(s) = 2^{-m/2} \sum_{i=1}^M \tau_i \psi(2^{-m}i - n), \quad (1)$$

where the scale variable  $m$  and the translation variable  $n$  are integers, and  $M$  represents the total number of R-R intervals analyzed. The discrete wavelet transform is evaluated at the points  $(m, n)$  in the scale–interval-number plane.

We have carried out this transformation using a broad range of orthonormal, compactly supported analyzing wavelets. We present results for both Daubechies 10-tap and Haar wavelets; similar results were obtained using other wavelets. Orthogonality in the DWT provides that the information represented at a certain scale  $m$  is disjoint from the information at other scales. Because certain wavelets  $\psi$  have vanishing moments, polynomial trends in the signal are automatically eliminated in the process of wavelet transformation [6,7,15]. This is salutatory in the case

of the heartbeat time series, as is evident from the trends apparent in Fig. 1b, which are eliminated by the wavelet transformation shown in Fig. 1d.

Since the signal  $s$  fluctuates in time, so too does the sequence of wavelet coefficients at any given scale, though its mean is zero [1]. In Fig. 2 we present histograms of the wavelet coefficients at six different scales ( $m = 2 - 7$ ) for a normal (left) and a heart-failure patient (right). The wavelet coefficients for the heart-failure patient evidently exhibit substantially reduced variability, particularly at intermediate scales. A natural measure for this variability is the wavelet-coefficient standard deviation, as a function of scale:

$$\sigma_{\text{wav}}(m) = \left[ \frac{1}{N-1} \sum_{n=1}^N (W_{m,n}^{\text{wav}}(s) - \langle W_{m,n}^{\text{wav}}(s) \rangle)^2 \right]^{\frac{1}{2}}, \quad (2)$$

where  $N$  is the number of wavelet coefficients at a given scale  $m$  ( $N = M/2^m$ ).

The principal results of this paper are displayed in Fig. 3, where  $\sigma_{\text{wav}}$  is plotted vs. scale ( $1 \leq m \leq 10$ ) for all of the 27 patients (open and solid circles) [14], using the Haar wavelet (left) and the Daubechies 10-tap wavelet (right). At scales 4 and 5, corresponding to  $2^4 - 2^5 = 16 - 32$  heartbeats,  $\sigma_{\text{wav}}$  serves to completely separate the two classes of patients for both types of wavelets (white regions), thereby providing a clinically significant measure [16,17] of the presence of heart failure with 100% sensitivity at 100% specificity (such that all normals are so identified). One can do no better. Though it has been previously shown that complete separation can be achieved using heart rate analysis [17,18], this is the first instance that we know of, in which the R-R intervals can be used as a definitive determinant of the presence of a heart disorder in an individual patient. Both at smaller, and at larger scales, there are multiple overlaps of the heart-failures and the normals, though the measure certainly remains statistically significant over all scales shown. Similar results are obtained for other analyzing wavelets.

The results indicate that healthy patients exhibit greater fluctuations than those afflicted with heart failure over a time scale of 16-32 heartbeats (roughly 0.2 to 0.5 minutes). This also appears to apply for sudden cardiac death (SCD) as illustrated by the open squares in Fig. 3. It is tempting to ascribe the physiological origin of this window to baroreflex modulations of the sympathetic or parasympathetic tone, which lie in the range 0.04 to 0.09 Hz (0.2 to 0.5 minutes), but we do not believe that this is correct. Rather, we expect that this window likely has its origin in the intrinsic behavior of the heart itself. It will be important to carry out a thorough study in which our multiresolution wavelet-analysis technique is applied to the R-R intervals from transplanted hearts to assess the role that the autonomic system might play in heart rate variability.

It is useful to tease apart the roles played by the *magnitudes*  $\tau_i$  of the interbeat intervals and their *ordering* in achieving this complete separation. The effects of the former continue to reside in the randomly reordered (shuffled) sequence of R-R intervals; however information about the ordering is removed in this surrogate data set [17]. We therefore calculate the standard deviation  $\sigma_{\text{wav}}^{\text{shuf}}$  for all 27 heartbeat time series after shuffling the R-R intervals. [The first 70 000 interbeat intervals were selected for analysis after the entire data sets (see Table 1 in Ref. [17]) were shuffled.] The results are shown in Fig. 4a. It is clear that the two classes of patients are no longer completely separated; three heart-failure patients fall among the normals at all scales, yielding a sensitivity of 80% at a specificity of 100%. Comparison with Fig. 4b shows that the shuffled-wavelet result is essentially identical to that obtained by using the standard deviation  $\sigma_{\text{int}}$  of the interbeat-interval histogram (IIH) obtained from these data sets, a measure that has long been used in cardiology [19,20]. The concurrence in sensitivity displayed in Figs. 4a and 4b is not accidental; the shuffled interbeat intervals essentially comprise a renewal process so that the IIH contains all of the available information. All dependencies among intervals, and therefore long-term correlations, are removed from the shuffled surrogate data [17], leaving behind only short-term information. Indeed, for the Haar analyzing wavelet,  $\sigma_{\text{wav}}(m=0)$  (in the absence or in the presence of shuffling) is analytically identical to  $\sigma_{\text{int}}$ .

The ordering of the interbeat intervals gives rise to scaling behavior, as is evident from a comparison of Figs. 3 and 4a. For normal patients (open circles, solid lines) the straight-line behavior in Fig. 3 indicates that approximate scaling is maintained across all scales whereas for heart-failure patients (filled circles, dashed lines) the relatively flat nature of the curves in the region  $m \leq 3$  indicates that  $\sigma_{\text{wav}}$  is essentially scale independent in this region.

The distinction can be examined quantitatively by calculating the average scaling exponents  $\alpha$  [21] in the two ranges ( $1 \leq m \leq 3$  and  $3 \leq m \leq 10$ ), for both classes of data. The results are reported in Table 1, along with the average scaling exponents determined across the entire scaling region examined ( $1 \leq m \leq 10$ ). It is clear that for the 12 normal patients, the value of  $\alpha$  is quite insensitive to the range over which it is estimated; it is nearly the same in the two subregions as it is in the entire range. For the 15 heart-failure patients, on the other hand, the scaling exponent estimated in the region  $1 \leq m \leq 3$  is dramatically lower than that estimated in the region  $3 \leq m \leq 10$ . Over the range of larger scales, the values of the scaling exponents  $\alpha$  provided by our wavelet measure (see Table 1), are in good accord with typical values  $\delta$  provided by the interval-based periodogram at low frequencies (see Table 1 in Ref. [17]), as expected. We conclude that scaling persists across a broader range for normal patients than it does for heart-failures, as is visually evident in Fig. 3.

These observations lead us to consider a heart-failure index determined by the difference of these scaling exponents:  $\Delta = \alpha(3 \leq m \leq 10) - \alpha(1 \leq m \leq 3)$ . Evaluating  $\Delta$  we find that two heart-failures fall among the normals, corresponding to a sensitivity of 87% at a specificity of 100%. Thus considering only the scaling information in  $\sigma_{\text{wav}}$ , while ignoring the magnitude differences for normals and heart-failures associated with short-term information (as illustrated in Fig. 4a), fails to give rise to complete separation.

Over the years, using this same collection of data, a number of measures based on scaling have been evaluated for their accuracy in discriminating between normal and heart-failure patients. Peng *et al.* [10] examined the correlation properties of the heartbeat-interval increments  $I_i = \{\tau_{i+1} - \tau_i\}$ , and obtained the exponent of the associated power-law spectrum, which they denoted as  $\beta$ . It was shown subsequently [17] that this measure is isomorphic to the exponent  $\delta$  of the interval-based spectrum [22] at low frequencies [23] and therefore reveals only long-term correlations. We have calculated  $\beta$  for all 27 data sets and present the results in Fig. 4c. This measure results in 7 heart-failures among the normals, yielding a sensitivity of 53% at 100% specificity, so that it is not particularly successful in discriminating the two classes of patients. The interbeat-interval standard deviation  $\sigma_{\text{int}}$  shown in Fig. 4b (sensitivity of 80% at 100% specificity) performs significantly better. In a subsequent paper, Peng and collaborators [11] constructed a "detrended fluctuation measure" which turns out to yield approximately 80% sensitivity at 100% specificity for the 27 data sets. Most recently, this same group introduced a so-called "scaling instability index" [12], which achieved a sensitivity of 71% at 100% specificity for the 25 (of the same 27) data sets that they reported, as shown in Fig. 4d. The performance of both of these latter measures is therefore comparable to that achievable with the interbeat-interval standard deviation measure  $\sigma_{\text{int}}$  introduced by Wolf *et al.* long ago [19]. As far as we are aware, no group has been able to successfully separate this standard collection of data with 100% sensitivity at 100% specificity using scaling measures alone.

We conclude that our multiresolution approach succeeds not only because it eliminates trends in a mathematically acceptable way, but also because it crisply reveals a range of scales over which heart-failure patients differ from normals, both in short- and long-term heartbeat behavior. In contrast, interbeat-interval measures reflect only short-term behavior, whereas scaling measures reflect only long-term behavior. Our approach should have wide applicability in the analysis of nonstationary processes in the physical and biological sciences.

We are grateful to S.B. Lowen for valuable comments.

FIG. 1. (a) Schematic diagram of an electrocardiogram segment, showing the beat occurrence times  $t_i$  and the interbeat (R-R) intervals  $\tau_i$ . (b) Series of interbeat intervals  $\tau_i$  versus interval number  $i$  for a typical normal patient (data set 16265). (Adjacent values of the interbeat interval are connected by straight lines to facilitate viewing.) Substantial trends are evident. (c) 3-D representation of the wavelet coefficient  $W$  as a function of scale ( $1 \leq m \leq 10$ ) and interval number  $i$ , over a portion of the data set, using a Daubechies 10-tap analyzing wavelet. (d) Wavelet coefficient at three scales ( $m = 2, 4, 8$ ) for the data set illustrated in Fig 1b. The trends in the original interbeat-interval time series are removed by the wavelet transformation.

FIG. 2. Typical histograms of the interbeat-interval wavelet coefficients for a normal patient (data set 16265, left panels) and for a heart-failure patient (data set 6796, right panels), for different values of the scale  $m$ , using a Daubechies 10-tap wavelet. The ordinate is the number of wavelet coefficients  $N$ . Heart-failure patients tend to have narrower distributions, particularly at intermediate scales.

FIG. 3. Wavelet-coefficient standard deviation  $\sigma_{\text{wav}}$  versus scale  $m$  for the standard 27 data-set collection (12 normals and 15 heart-failures indicated by circles) [14], using the Haar wavelet (left) and the Daubechies 10-tap wavelet (right). Complete separation of the two groups is achieved at scales 4 and 5, corresponding to  $2^4 - 2^5$  heartbeats. Results for an SCD patient (white squares), using the same number of interbeat intervals, also exhibit low variability. The outcome is similar for both analyzing wavelets, though the separation is slightly more pronounced for the Daubechies wavelet, most likely because of its greater number of vanishing moments.

FIG. 4. (a) Wavelet-coefficient standard deviation  $\sigma_{\text{wav}}^{\text{shuf}}$  versus scale  $m$  for the standard 27 data-set collection [14] after random reordering of the R-R intervals (shuffling), using a Daubechies 10-tap wavelet. Partial separation of the two groups is achieved; three heart-failure patients fall among the normals at all scales, yielding a sensitivity of 80% at a specificity of 100%. (b) Standard deviation of the interbeat intervals  $\sigma_{\text{int}}$  for all 27 data sets. This measure was first used by Wolf *et al.* [19]. Three heart-failure patients fall among the normals, corresponding to a sensitivity of 80% at 100% specificity. (c) Exponent  $\beta$  of the heartbeat-interval increment-process spectrum for all 27 data sets; this measure was used by Peng *et al.* [10]. Seven heart-failures fall among the normals, yielding 53% sensitivity at 100% specificity. (d) The “scaling instability index,” recently introduced by Peng and collaborators [12], and reported by them for 25 of the same 27 data sets. Four heart-failures fall among the normals, yielding 71% sensitivity at 100% specificity, still falling short of our multiresolution results shown in Fig. 3 which yield 100% sensitivity at 100% specificity.

Interbeat Intervals (27 Patients)				
Class of Patients	Results			
	$\langle \tau_i \rangle$	$\alpha(1 \leq m \leq 10)$	$\alpha(1 \leq m \leq 3)$	$\alpha(3 \leq m \leq 10)$
Normal (12)	$0.79 \pm 0.08$	$1.23 \pm 0.13$	$1.40 \pm 0.37$	$1.22 \pm 0.11$
HF (15)	$0.67 \pm 0.13$	$1.35 \pm 0.22$	$0.26 \pm 0.60$	$1.57 \pm 0.17$

TABLE I. Mean interbeat intervals and estimated scaling exponents  $\alpha$  (with their standard deviations) for the 12 normal and 15 heart-failure patients, collected in two separate groups. Scaling-exponent estimates are evaluated over the whole range of  $m$ , as well as over two smaller scaling subregions:  $1 \leq m \leq 3$  and  $3 \leq m \leq 10$ . The scaling behavior is significantly different for the two groups of patients. The difference of the scaling exponents in the two subregions,  $\Delta = \alpha(3 \leq m \leq 10) - \alpha(1 \leq m \leq 3)$ , leads to a sensitivity of 87% at 100% specificity.

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[1] I. Daubechies, *Ten Lectures on Wavelets* (Society for Industrial and Applied Mathematics, Philadelphia, PA, 1992).

[2] S. Mallat, IEEE Trans. Pattern Anal. Mach. Intel. **11**, 674-693 (1989).

[3] Y. Meyer, *Ondelettes et opérateurs* (Hermann, Paris, 1990).

[4] A. Aldroubi and M. Unser, eds., *Wavelets in Medicine and Biology* (CRC Press, Boca Raton, FL, 1996).

[5] M. Akay, ed., *Time Frequency and Wavelets in Biomedical Signal Processing* (IEEE Press, Piscataway, NJ, 1997).

[6] A. Arneodo, G. Grasseau, and M. Holschneider, Phys. Rev. Lett. **61**, 2281-2284 (1988).

[7] M.C. Teich, C. Heneghan, S.B. Lowen, and R.G. Turcott, in *Wavelets in Medicine and Biology* (CRC Press, Boca Raton, FL, 1996), pp. 383-412.

[8] R.I. Kitney, D. Linkens, A.C. Selman, and A.H. McDonald, Automedica **4**, 141-153 (1982).

[9] J.B. Bassingthwaite, L.S. Liebovitch, and B.J. West, *Fractal Physiology* (Oxford Univ. Press, New York, 1994).

[10] C.-K. Peng, J. Mietus, J.M. Hausdorff, S. Havlin, H.E. Stanley, and A.L. Goldberger, Phys. Rev. Lett. **70**, 1343-1346 (1993).

[11] C.-K. Peng, S. Havlin, H.E. Stanley, and A.L. Goldberger, Chaos **5**, 82-87 (1995).

[12] G.M. Viswanathan, C.-K. Peng, H.E. Stanley, and A.L. Goldberger, Phys. Rev. E **55**, 845-849 (1997).

[13] P.C. Ivanov, M.G. Rosenblum, C.-K. Peng, J. Mietus, S. Havlin, H.E. Stanley, and A.L. Goldberger, Nature **383**, 323-327 (1996).

[14] The R-R recordings were drawn from the Beth-Israel Hospital (Boston, MA) Congestive Heart-Failure Database comprising 12 records from normal patients (age: 29-64 years, mean 44 years) and 15 records from severe congestive heart-failure patients (age 22-71 years, mean 56 years). The recordings, which form a standard database for evaluating the merits of various measures for identifying heart-failure, were made with a Holter monitor, digitized at a fixed value of 250 Hz. Three of the 15 heart-failure patients also suffered from atrial fibrillation. Detailed characterization of the data sets is presented in Table 1 of Ref. [17]. We used the first  $M = 70\,000$  interbeat intervals (total time duration  $T \approx 20$  h) of each of these records.

[15] P. Abry and P. Flandrin, in *Wavelets in Medicine and Biology* (CRC Press, Boca Raton, FL, 1996), pp. 413-437.

[16] J.A. Swets, Science **240**, 1285-1293 (1988).

[17] R.G. Turcott and M.C. Teich, Ann. Biomed. Eng. **24**, 269-293 (1996).

[18] R.G. Turcott and M.C. Teich, Proc. SPIE **2036** (*Chaos in Biology and Medicine*), 22-39 (1993).

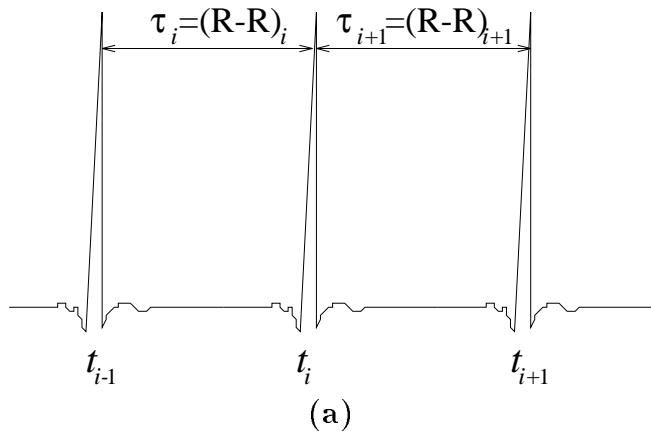
[19] M.M. Wolf, G.A. Varigos, D. Hunt, and J.G. Sloman, Med. J. Australia **2**, 52-53 (1978).

[20] R.E. Kleiger, J.P. Miller, J.T. Bigger, A.J. Moss, and the Multicenter Post-Infarction Research Group, Am. J. Cardiol. **59**, 256-262 (1987).

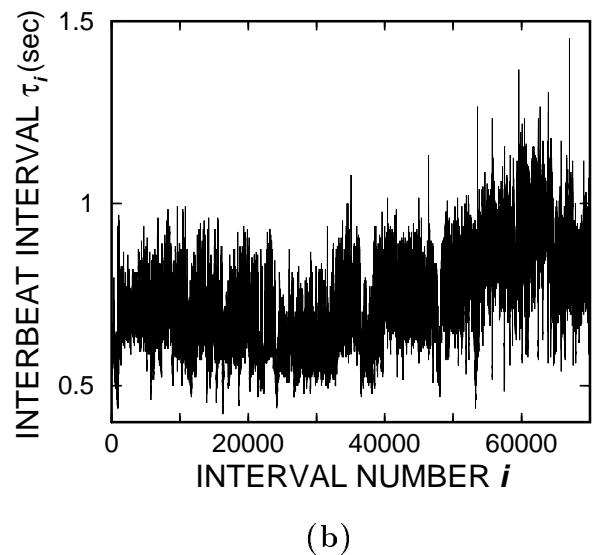
[21] The scaling exponent  $\alpha$  is computed from an individual wavelet-coefficient standard-deviation curve (as shown in Fig. 3) by calculating the slope of its square (rendering it a variance so that it corresponds to other standard scaling-exponent measures) on a base-10 log-log plot. Thus  $\alpha = [d(\log_{10}\sigma_{\text{wav}}^2(m))]/[d(\log_{10}2^m)] = [2/\log_{10}2][d(\log_{10}\sigma_{\text{wav}}(m))/dm]$ .

[22] S. Akselrod, D. Gordon, F.A. Ubel, D.C. Shannon, A.C. Barger, and R.J. Cohen, Science **213**, 220-222 (1981).

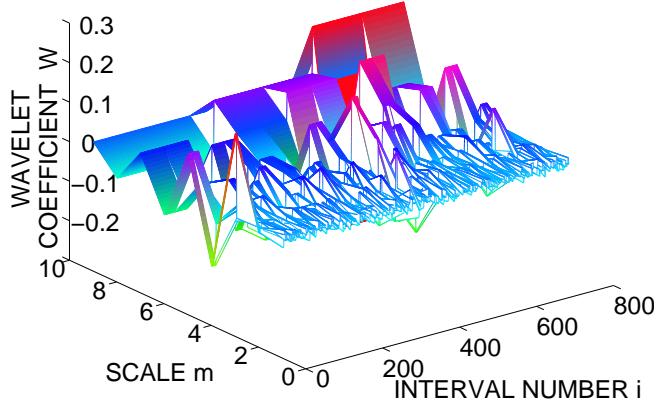
[23] M. Kobayashi and T. Musha, IEEE Trans. Biomed. Eng. **BME-29**, 456-457 (1982).



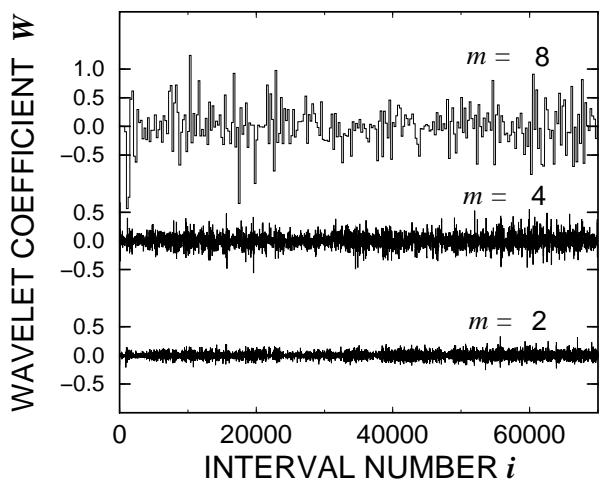
(a)



(b)

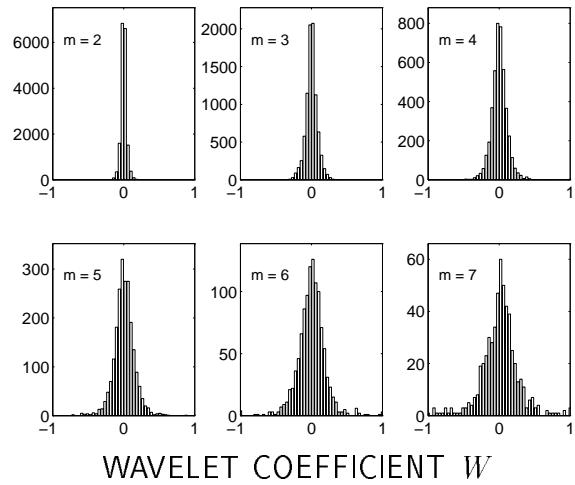


(c)

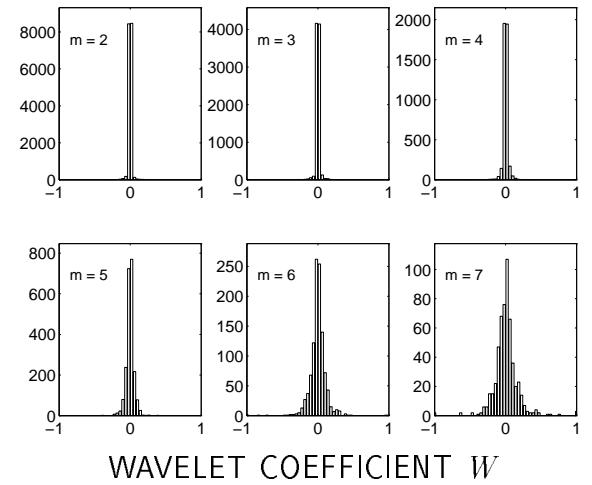


(d)

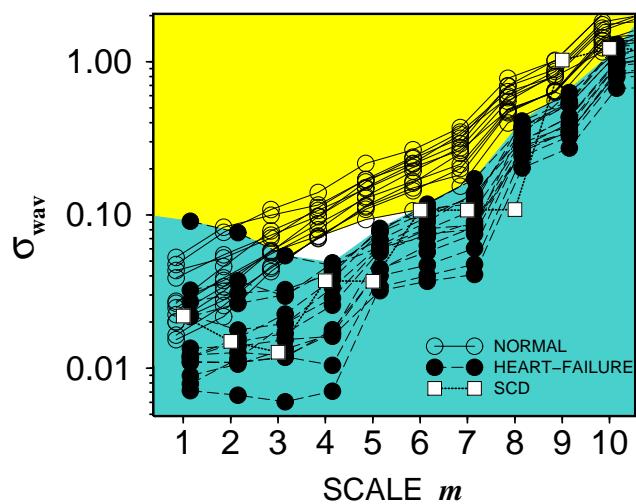
**Normal**



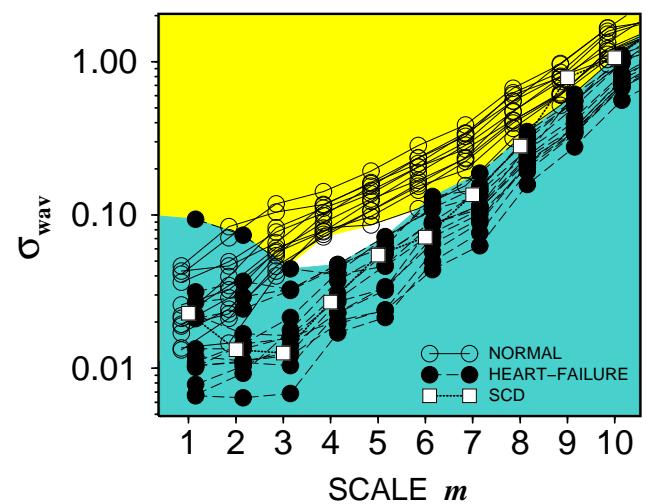
**Heart-Failure**

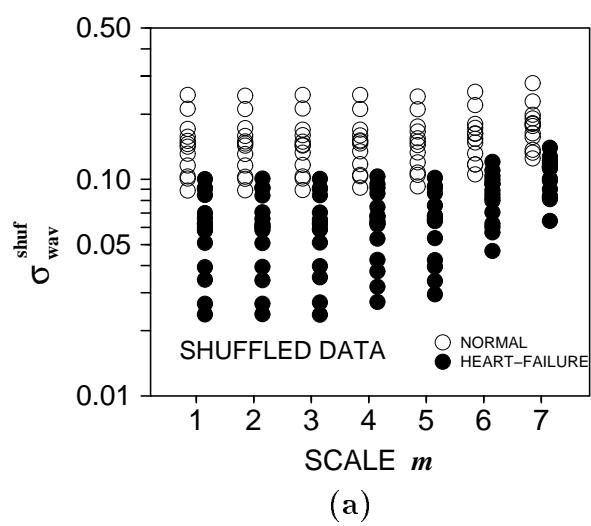


Haar wavelet

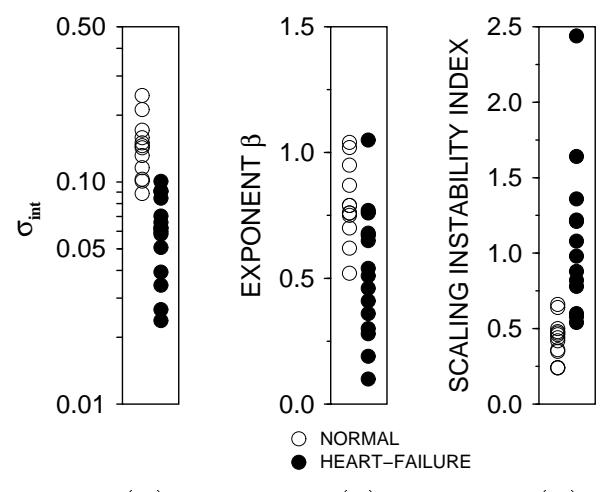


Daubechies 10-tap wavelet





(a)



(b)

(c)

(d)